The NHS at 60: the next 60 years

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Introduction

At its introduction, the National Health Service was described by the Secretary of State for Health, Aneurin Bevan, as 'the biggest single experiment in social service that the world has ever seen undertaken'.[1] The 1946 NHS Act had ambitious objectives:

> *'The Bill imposes no limits on availability – e.g. limitations based on financial means, age, sex, employment or vocation, area of residence or insurance qualification… The Bill places a general duty upon the Minister of Health to promote a comprehensive health service for the improvement of the physical and mental health of the people of England and Wales, and for the prevention, diagnosis and treatment of illness.'*[2]

Through funding largely from taxation, the government sought to provide a secure financial foundation for health services in Britain, avoiding reliance on charity, which Bevan described as 'repugnant to a civilised community'.[3] The service aimed to provide care for the whole population, free at the point of use.

Despite contentious debate around its creation and early concerns, the NHS quickly became embedded in British society. It has amassed a consensus of public and political support that is perhaps unique. Margaret Thatcher stated that she 'always regarded the NHS and its basic principles as a fixed point in our policies'.[4] Successive governments, while reforming structures of delivery, have all retained a system where care is provided 'based on need, not ability to pay'.[5]

This apparent political consensus conceals a number of persistent debates, which are likely to continue to dominate NHS policy making over the next sixty years.

The balance of prevention, primary and secondary care

Despite the explicit aims of the 1946 NHS Act, which included prevention as well as treatment, and overall improvement of population health, dominance of the hospital sector meant that the NHS was referred to early in its existence as a 'national hospital service'.[6] The balance between prevention and cure, and between primary and secondary care, remains uneven, maintaining fragmented service delivery.

Divisions emerged long before the creation of the NHS. Separation of general practitioners and hospital specialists is historic, but was reinforced by the panel doctor system built into the 1911 National Insurance Act, which provided insurance coverage only for GP services. The sudden nationalization of the hospital stock in 1948 made hospital-based doctors public employees. In contrast, general practitioners – who operated 'on the small shopkeeper principle'[7] – retained independent practitioner status and their role as first contact with the health care system. The hospital became dominant in expenditure terms early on in the existence of the NHS; at the beginning of the health service, hospitals cost around 54% of the budget, and this increased to around 70% by 1975.[6] Attempts to create a 'primary care led NHS' since the 1990s reflect the perceived imbalance.

It is remarkable how the divisions between professionals and institutions inherited in 1948 have persisted for 60 years, despite continued advocacy of integrated approaches to health care provision. Initially hospital budgets were cash limited and primary care budgets were demand determined – each remained separate and focused on their own objectives. Historically there were no financial incentives for hospitals to increase the number of patient episodes, and GPs bore none of the financial consequences of their referral decisions. Over time this mismatch between demand side and supply side incentives resulted in substantial waiting lists and waiting times, a major political issue for the NHS.

The introduction of the internal market in the 1990s, developed with 'payment by results' since 2002, has attempted to introduce clear financial

incentives to increase hospital activity rates and reduce waiting times. Hospitals are now rewarded for each patient episode, and are increasingly expected to compete with other local providers (now in the private sector as well as other NHS hospitals) as a result of 'patient choice'. This creates supply side incentives to increase activity.

On the demand side, the Thatcher reforms adopted academic advocacy of a more integrated approach[8] almost accidentally, by adding GP fundholding to the reform agenda in 1989. Fundholding introduced real budgets and explicit financial incentives for GPs to contain costs of prescribing and elective referrals, which were eventually demonstrated to have had an effect.[9] GP fundholding was 'abolished' in 1997, replaced by Primary Care Trusts, responsible for providing primary care and commissioning secondary care. This diluted the incentive structure – while GPs as a group may be affected by financial constraints in their PCT, the direct link between their decisions and the financial consequences is substantially weakened. Fundholding is now re-emerging as practice-based commissioning, but incentive structures remain inadequate.

Whilst primary and secondary care grew and remained fragmented, prevention was largely poorly funded and badly managed. The NHS Bill and preceding discussion papers highlighted the importance of preventive health – as far back as 1941, in Beveridge's early papers, prevention was at the forefront of plans for the NHS.[10] But in practice, resources and responsibility for preventive health remain marginal. High-profile public health campaigns have been run from central government with varying levels of success, but the NHS responsibility for preventive health is less clear. Bodies such as the Health Education Council focused principally on media campaigns, and the development of an evidence base of effectiveness and cost-effectiveness was neglected. This is partly due to the lack of a strong lobby group for prevention, particularly relative to the dual forces of the medical profession and the pharmaceutical industry in lobbying for treatments.

Whilst PCT Directors of Public Health and are responsible for preventive health they have failed to develop substantial budgets for investments in this area. For example, with regard to obesity, NICE guidance has reinforced use of bariatric surgery and pharmaceutical interventions, but increasing levels of obesity continue. 'Up-stream' investments targeted at cause rather than effect are stymied due to a poor evidence base, and investments in the Campbell Collaboration,[11] which seeks to identify the effectiveness and cost-effectiveness of a broad range of social programmes, remains inadequate. The integration of clinical and public health guidance in key health areas such as obesity is an interesting development from NICE in the context of balancing prevention and treatment, but it highlights the difference in existing levels of evidence of public health and clinical interventions, and the need for more robust research in how to change individual health behaviour.

The robustness of the primary-secondary care division and the underdevelopment of prevention may continue in the future. The current government places great faith in tariff payment systems, initially designed for hospitals, which may in future be expanded to cover mental health, community care and even primary care. This is a payment for activity, which usually induces increased service provision and then a consequent need to cap volume and expenditure levels in order to avoid cost inflation. Although tariffs enhance transparency, and make activity and practice variations clearer, in the absence of outcome measurement, incentivization of process has uncertain effects on efficiency. Practice-based commissioning may increase accountability and induce greater integration of care, for example the use of disease-specific patient pathways across primary and secondary care. Such collaboration between traditionally isolated sectors, if objectives are shared, may lead to merger, particularly where there are potential economies of scale and scope.

The tensions between prevention and cure, and between primary and secondary care, are largely due to historical incentive structures within the NHS. Addressing these structures to provide an appropriate framework for a national *health* service, rather than a national *sickness* service, is a key challenge for the next 60 years. The merits of US-style Health Maintenance Organizations such as Kaiser Permanente[12] may lead to emulation in England, with vertical integration of primary and secondary care. An organization paid on a capitation basis with responsibility for all of primary and secondary care would in principle have clear incentives to keep patients healthy and to avoid hospital episodes. This could potentially begin to redress the balances between prevention and cure, and between primary and secondary care. If this were underpinned by investment in the evidence base for prevention, the objectives of Beveridge and Bevan to prevent as well as treat disease may finally be addressed.

Pay and performance of health care professionals

'The unnerving discovery every Minister of Health makes at or near the outset of his term of office is that the only subject he is ever destined to discuss with the medical profession is money.' J Enoch Powell (1966)[13]

The methods of payment of doctors in primary and secondary care also reflect history rather than a clear attempt to incentivize efficient patient care. Bevan maintained and reinforced the existing divide between specialists and general practitioners. Tensions between medical professionals and government over personal income and professional autonomy were established in the first contractual negotiation of 1948 and recur throughout the history of the NHS.

GPs were induced to work in the NHS only after fierce negotiations. Bevan conceded a method of payment by capitation fee for each patient, as in the National Insurance Act in 1911, and also gave considerable freedom to GPs to operate as independent contractors to the NHS.[14] Capitation facilitates expenditure control but reveals nothing about the process or outcomes of primary care. Prior to 1990 the GP contract defined the role only in extremely vague terms. This lack of clarity of contract led government to gradually add service delivery obligations, often incentivising them with fees for service (e.g. for minor surgery) and target payments (e.g. for childhood immunizations and cervical screening). Difficulties in recruitment and retention, particularly in some geographical and service areas, led to development of a salaried option of payment in 1997 but this also reveals little about practice process and outcome.

Concerns about variations in use of demonstrably cost-effective primary care led to a new contract in 2004. The quality and outcomes framework (QOF) rewards performance using explicit financial incentives – a clear example of performance-related pay. The contract has been criticized, partly for its cost and its relative generosity in the first years of its operation – the contract was reported to have cost the Department £1.76 billion more than it originally budgeted for, without clear indications of all of the QOF targets improving patient health.[15] It over-rewarded GPs for work they were already doing (or should have been), and its partial coverage could lead to neglect of treatments not in the QOF.[16] There is, however, flexibility to change the targets within the QOF in order to continue to stimulate improved performance and reflect changing priorities over time. Historically the NHS has operated on a basis simply of trusting doctors to work in the interests of patients and the health service (interests which do not always coincide). In general practice this trust is increasingly being supplemented with financial incentives to improve performance.

Similar issues affect the pay and contracts of NHS hospital specialists. Again, the personal income and professional autonomy of medical practitioners were keys to obtaining the support of the consultants for the introduction of the NHS. They were assured a stable and relatively generous salary, teaching hospitals were given special status, encouraging cooperation from those at the top of the medical profession, and two additional elements of pay were conceded, averting potential opposition. First, there was a continued right to private practice in hospital pay beds; and second, a system of awards was introduced to give special financial rewards to those consultants deemed 'meritorious' by their peers. Both these supplements to the NHS salaries of hospital consultants remain in some form today. Bevan was reported, perhaps apocryphally, to have said that he 'stuffed their mouths with gold'.[17]

The salary-based contract, with additional rewards and minimal 'management' of consultants, has persisted. Attempts to revise the pay and contracts of consultants during the 1974 Labour government were 'explosive', resulting in 'the most bitter political struggle since the inception of the NHS'.[7] Minor changes resulted in 1979, but these were very limited in scope, and the lack of explicit accountability, management or regulation, as in earlier contracts, remained. While there is potentially greater transparency in the process of hospital care compared with general practice, as activity data at consultant level exists,[18] these data are rarely used by clinicians or managers to inform practice. The 2004 consultant contract gave practitioners large pay increases but no attempt was made to incentivize activity or reduce variations, despite a trend of falling productivity.[19]

Activity data, such as that obtained from Hospital Episode Statistics and tariff payments, are inadequate to guide management of or by clinicians. Patient-level costs and patient reported outcome measures are also needed. Outcome measures are planned from April 2009 for a narrow range of elective procedures,[20] and patient-level costs are also under development to complement payment by results. This three-fold information on activity, costs and outcomes of hospital care has the potential to enhance the performance of hospitals and individual clinicians. But this may require additional direct incentives or

additional management of professionals – in the words of Canadian economist Morris Barer, you can 'pay 'em or flay 'em'. There are significant investments in performance-related pay for health care professionals worldwide, but although this is in place for GPs in the NHS, it is not yet used for hospital consultants. Financial incentives in terms of bonuses and penalties can be a catalyst for change at the margin, but evidence about the cost-effectiveness of performance-related pay is very limited and such innovation should be designed and evaluated with care.[21] Contracts, whether based on financial incentives or management and monitoring, can never be complete, and most contracts in health care are based on trust and self-management. This trust has been eroded over time, with increasing awareness of errors and inadequate performance.

Whether the next 60 years of the NHS continues the approach of allowing medical professionals to manage their own performance, or develops further models of performance-related pay, both require improved transparency, informed by good data on activity, cost and outcomes. If transparency and accountability are not enhanced by the provision of activity, cost and outcome data there is a risk that performance-related pay reforms could replace trust as the engine of performance. Careful deployment of such incentives alongside evaluation to monitor its effects is essential.

Rationing health care

The final recurring theme, present throughout the last 60 years and no doubt into the next 60, is the thorny question of rationing health care. The optimistic view of those designing the early NHS that expenditure would fall over time, as the population became more healthy, was eliminated as expenditure increased substantially when the NHS 'had barely begun'.[14] Much of the debate at the time was around prescription expenditure, and even Bevan is reported as commenting on the 'cascade of medicine pouring down British throats'.[22] The early concern about expenditure was allayed by the Guillebaud committee of 1956,[23] which found that the anxiety was not justified. This was not, however, before the Treasury had forced the government into introducing charges for prescriptions and some other health services, viewed by Bevan as ending free care, and precipitating his resignation. Although the creation of the NHS was accompanied by substantial technical advances in medicine, including the wide use of antibiotics, during the first few decades the limits of medicine were generally around what could be done. As technology improved over the years, increasing debates over what the NHS is able to fund emerged.[24] In 1999 the National Institute of Clinical Excellence (NICE) was given the role of deciding what new products will be reimbursed by the NHS, and aimed to make these decisions in an objective and transparent manner. While the process has not been without its critics[25] the basic principle of using economic as well as clinical evidence in justifying funding decisions appears to have been largely accepted.

The future of rationing health care will provide a key battleground for the NHS. Recurrent calls for broadening the funding base of health care in Britain, for example by increasing user charges for care[26] and introducing 'top-up fees' to permit patients to bypass NICE recommendations and receive the pharmaceuticals they want[27] reflect the increasing consumer society and an individualist approach to health care. This is still resisted by those who see health care as a collective responsibility, and who value the NHS not just for its provision of health care at reasonable cost but for its social cohesion and universality. As yet NICE is partial in its recommendations, in particular it tends to focus on new therapies, and its thorough and consultative process takes time. Over the last nine years it has appraised only around 130 new technologies[25] and this means that in practice the majority of rationing decisions still lie with PCTs. In response, a Public Health Commissioning Network is currently being piloted to offer quick assessments of new drugs and other treatments.[28] This organization could compete with NICE, and it may be difficult for NICE to refuse a treatment that is already in widespread use. In future, NICE must continue to evolve and to broaden its focus to include existing treatments as well as new ones, and to produce recommendations of what should be removed as well as what should be introduced.

Conclusions

The creation of the NHS 60 years ago was, as described by the then Secretary of State, a large social experiment. Subsequent reforms have also been large and usually expensive experiments. Like policy reforms internationally, these changes have often used theory and evidence incompletely, and evaluations of many of the reforms have been partial or non-existent. The effects of GP fundholding, for example, were only made apparent by rigorous evaluation after its abolition.[9] More recently, opportunities to evaluate the effect of the

new GP contract were missed by the lack of baseline data collection before its implementation.

Cochrane, a leading advocate of the evidence-based medicine movement, believed in the potential of experimental evaluation not only to improve medical care, but in its applicability in social work, education, criminology and other areas of policy.[29] In these fields, and in health policy, evaluation has been less common, and less scientifically rigorous when used: advocacy of an evidence-based approach has been less successful.[30] To resolve the debates outlined above, in the next 60 years of the NHS the lack of scientific basis for health policy reforms must be addressed. The cost of knowledge is great but the price of ignorance may be much greater.

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